2100 INTRODUCTION

The Home and Community Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in intermediate care facilities for persons with mental retardation, can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for the Persons with Mental Retardation and Related Conditions originated in 1982. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Mental Health and Developmental Services Division (MHDS) and by the Division of Health Care Financing and Policy (DHCFP) (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing person's with mental retardation or related conditions with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are have mental retardation or a related condition are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The division is committed to the goals of self-sufficiency and independence.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

2101 AUTHORITY

Section 1915 (c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. Nevada Medicaid's Home and Community-based Waiver for Person's with Mental Retardation or Related Conditions is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

Nevada Medicaid has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- Social Security Act: 1902 (A)
- Social Security Act: 1902 (w)
- Code of Federal Regulations (CFR) (Title 42) 435.1009,
- CFR (Title 42) Part 431, Subpart E
- CFR (Title 42) Part 441, Subparts G and I
- CFR (Title 42) Part 483.430(a)
- State Medicaid Manual 4440
- Omnibus Budget Reconciliation Act of, 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada's Home and Community Based Waiver Agreement for Person's with Mental Retardation and Related Conditions
- Nevada Revised Statutes (NRS) Chapter 232.357
- NRS Chapter 422
- NRS Chapter 424
- NRS Chapter 432.A.024
- NRS Chapter 433
- NRS Chapter 435
- NRS Chapter 449.004
- Nevada Administrative Code (NAC) Chapter 435
- NAC Chapter 639

2102 DEFINITIONS

These are brief definitions, full detail is located in the section addressing the definition.

2102.1 ACTIVITIES OF DAILY LIVING (ADLS) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

Activities of daily living (ADL) are self-care activities routinely performed on a daily basis, such as bathing, dressing, toileting, transferring, and eating.

Instrumental Activities of Daily Living (IADLs) capture more complex life activities and include light housekeeping, laundry, meal preparation and grocery shopping.

2102.2 ASSESSMENT

A written assessment of each waiver applicant/recipient, using approved assessment tools and other clinical assessment information, which includes the individual's abilities to perform activities of daily living, the individual' medical and social needs, the individual's support system and all other services received currently by the individual. This assessment identifies the support needs addressed in the support plan.

2102.3 DAILY RECORD

The daily documentation completed by a provider indicating the time spent and the services Provided. This record needs to be signed by the service provider and the recipient each visit. This is not a medical record. This is a claim review record.

2102.4 FUNCTIONAL ASSESSMENT

An assessment process that identifies the ability/inability of an individual to perform ADLs (Activities of Daily Living) such as personal hygiene, mobility, toileting, etc., and IADLs, (Instrumental Activities of Daily Living) such as shopping and light housekeeping. This assessment identifies an applicant/ recipient's unmet needs and provides a mechanism for determining service hours based on medical necessity. The functional assessment is designed to evaluate both the environment in which services are provided and the availability of support systems. This assessment is used to develop the applicant's/recipient's PCA Service Plan.

2102.5 HABILITATION SERVICES

Service designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Included in this waiver are:
-Residential Habilitation

-Day Habilitation
-Prevocational Services
-Educational Services
-Supported Employment Services
-In Home Habilitation

2102.6 INDIVIDUAL SUPPORT TEAM (IST)

Service Coordinators/targeted case managers, in partnership with the recipient and people who know the recipient well, determine the level and type of service and supports for each recipient using approved assessment tools and other clinical assessment information related to risks to health and safety for the recipient and/or community and the recipient's needs for medical and physical care.

2102.7 INTERMEDIATE CARE FACILITY FOR MENTALLY RETARDED OR PERSON'S WITH RELATED CONDITIONS (ICF/MR) LEVEL OF CARE

"Facility for intermediate care" means an establishment operated and maintained to provide 24-hour personal and medical supervision, for a person who does not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. Persons in this facility must have a diagnosis of mental retardation or a condition related to mental retardation. This level of care identifies if an individual's total needs are such that they could be routinely met on an inpatient basis in a ICF/MR.

2102.8 MENTAL HEALTH AND DEVELOPMENTAL SERVICES DIVISION (MHDS)

A State agency that is part of Nevada's Department of Human Resources. MHDS is contracted to operate the Home and Community-based Waiver for Person's with Mental Retardation and Related Conditions, provide service coordination through the Targeted Case Management Service and be the fiscal intermediary for waiver service providers.

2102.9 MENTAL RETARDATION

Mental retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period. A diagnosis of mental retardation is made based on commonly used standardized tests of intelligence and standardized adaptive behavior instruments.

2102.10 RELATED CONDITION

Person's with conditions related to metal retardation are persons who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy; or any other condition, other than

mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22. It is likely to continue indefinitely. It results in substantial functional limitations in three or more of the following areas of major life activity:

-Taking care of oneself;
-Understanding and use of language;
-Learning;
-Mobility;
-Self-direction;
-Capacity for independent living.

2102.11 RESPITE SERVICE

Services provided to recipients unable to care for themselves, furnished on a regular or intermittent basis because of the absence or need for relief of those persons normally providing the care. This is a component of the Family Support Arrangement Service.

2102.12 SERVICE COORDINATION TARGETED CASE MANAGEMENT

A Medicaid State Plan service that completes the case management duties for the recipients on this waiver. These targeted case managers are referred to as service coordinators in the waiver program. The service assists recipients to access needed home and community based waiver services, Medicaid state plan services, as well as needed medical, social, educational, and all other services, regardless of the funding source for the services to which access is gained.

2102.13 SERVICE PLAN

A service plan is the written description of personal care service needs developed by Nevada Medicaid staff or Medicaid's designee and the recipient or the recipient's personal representative. It outlines those specific tasks which the PCA is authorized to provide for the recipient.

2102.14 SKILLED SERVICES

Services that are inherently complex and require the specialized training of a nurse or therapist to safely and effectively provide.

2102.15 SLOT

The number of available openings which may be offered to eligible recipients during each fiscal year. The number of slots available are determined by the level of legislative funding approved per fiscal year and through an agreement with CMS to fund this number of slots.

Open slots refer to the number of recipient on the waiver on any one day.

Unduplicated slots are the total number of recipient who are on the waiver in a specific time period.

2102.16 SUPPORT PLAN

The support plan is a written document which identifies all of the applicant's or recipient's care and support needs. The support plan is based on an assessment of the applicant's/recipient's health and welfare needs and developed by the targeted case manager/service coordinator, in conjunction with each applicant/recipient and or his or her authorized representative.

2102.17 WAITING LIST

The list of waiver applicants who have been pre-screened and deemed eligible for the waiver and are waiting for a funded waiver slot.

2102.18 WAIVER YEAR

For the waiver for person's with mental retardation and related conditions, the waiver year begins on October 1 and ends on September 30.

2103 POLICY

2103.1 ELIGIBILITY CRITERIA

Nevada Medicaid's Waiver for the Person's with Mental Retardation and Related Conditions waives certain statutory requirements and offers home and community-based services to eligible recipients to assist them to remain in the community.

2103.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in an intermediate care facility for persons with mental retardation. Recipients on the waiver must meet and maintain Medicaid's eligibility requirements for the waiver.

2. The Home and Community-Based Waiver for Person's with Mental Retardation or Related Conditions is limited, by legislative mandate, to a specific number of recipients who can be served through the waiver per year (termed slots). When all waiver slots are full, a waiting list is utilized for applicants who have been presumed to be eligible for the waiver.

3. Waiting List Prioritization
   a. First priority are residents of an intermediate care facility for person's with mental retardation or related conditions.
   b. Second priority are applicants who are at risk of institutionalization due to loss of their current support system; either the loss of current service funding, such as aging out of the school system or the loss of family supports due to family crisis.
   c. Third priority are applicants already on the waiver for Person's with Mental Retardation or Related Conditions waiting list who do not meet "a" or "b".

4. Medicaid must assure CMS that Medicaid's total expenditures for waiver and Medicaid services state plan will not, in any calendar/waiver year, exceed 100 percent of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. Medicaid must also document that there are safeguards in place to protect the health and welfare of recipients.

5. Waiver services may not be provided while a recipient is an inpatient of an institution.

6. The Waiver for Person's with Mental Retardation or Related Conditions Eligibility Criteria:

   Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Waiver for Person's with Mental Retardation or Related conditions.

a. Eligibility for Medicaid's Waiver for Person's with Mental Retardation or Related Conditions is determined by the combined efforts of the Division of Mental Health and Developmental Services (MHDS), the Division of Health Care Financing and Policy (DHCFP) and the Nevada State Welfare Division (NSWD). Two separate determinations must be made for eligibility for the Waiver:

1. Service eligibility for the waiver is determined by MHDS regional office staff and authorized by Medicaid's central office staff.

a. A MHDS Regional Center Intake Process, based on supporting documentation, establishes the existence of mental retardation or a related condition.

b. Each applicant/recipient must meet and maintain a level of care category for admission into an intermediate care facility for person's with mental retardation and related conditions. The recipient would require imminent placement in an ICF/MR facility (within 30 to 60 days) if Home and Community Based Waiver services or other supports were not available.

c. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an intermediate care facility for the mentally retarded. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

d. The applicant/recipient must have an adequate support system to provide a safe environment during the hours when home and community based services are not being provided.

2. Eligibility determination for full Medicaid benefits is made by the Welfare Division.

a. Recipients of the Waiver for Person's with Mental Retardation or Related Conditions must be Medicaid eligible for full Medicaid benefits for all months in which waiver services are provided.

b. Services from the waiver for Person's with Mental Retardation or Related Conditions cannot be provided until and unless the applicant is found eligible in both determination areas.

c. Medicaid recipients in the Waiver for Persons with Mental Retardation or Related Condition may have to pay for part of the

cost of the waiver services. The amount they are required to pay is called patient liability. SSI recipients do not have any patient liability.

1. Patient liability is determined by the Eligibility Certification Specialist (ECS) in the local Welfare Division district office. The following are excluded when determining patient liability:

   a. A maintenance allowance to care for the recipient's needs (rent, utilities, food, etc.) in the amount of 300% of the SSI need standard.

   b. A maintenance allowance for the spouse/dependent child(ren) (the ECS determine if the family members qualify for the deduction and the allowable amount of the deduction).

   c. Payments made by the recipient for health insurance premiums, deductibles and co-insurance charges not paid by Medicaid or other insurance, except for Medicare.

   d. Payments made by the recipient for medical care, recognized under State law, but not covered by the Medicaid program or other insurance. Payments for care which are above the Medicaid program limits are not excluded when determining patient liability.

2. When a case is approved or patient liability changes, the recipient, MHDS and Medicaid's fiscal intermediary are notified by the ECS of the patient liability amount and the effective date. MHDS will be notified only if there is a patient liability amount. Collection of patient liability is the responsibility of MHDS.

   Patient liability for new approvals is effective on the first day of the month of approval.

   When a recipient's income changes, patient liability is adjusted beginning with the month of the change. ECS notifies MHDS of this change.

3. When a recipient is discharged from the waiver, patient liability is prorated according to the number of days the recipient received waiver services during the month. If patient liability is inadvertently collected before discontinuing waiver services, the remaining balance, as determined by the ECS, must be refunded to the patient.

4. The actual amount of the patient liability is either the amount determined by the ECS or the actual cost of waiver services during the month, whichever is less. This amount is deducted from the amount billed to Medicaid for waiver services whether or not it is collected from the recipient. If no waiver service are provided during a month (e.g., a new case where services aren't initiated until after Medicaid eligibility approval), there is no patient liability.

5. Failure to pay patient liability is grounds for termination of waiver services.

7. Recipients of the Waiver for Persons with Mental Retardation or Related Conditions who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community that are not covered under the hospice program. Regardless of the recipient's payment source for the hospice services, certain waiver services will no longer be payable by Medicaid as they are covered in the hospice program or are not palliative or basic self care. Refer to Medicaid Services Manual Chapter 3200 for additional information on hospice services.

2103.1B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month.

2. MHDS is responsible to collect any patient liability.

2103.1C RECIPIENT RESPONSIBILITIES

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Waiver for Person's with Mental Retardation or Related Conditions.

MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the waiver for people mental retardation or related conditions receive all the medically necessary Medicaid coverable service

available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.2 WAIVER SERVICES

Nevada Medicaid determines which services will be offered under the Waiver for Person's with Mental Retardation or Related Conditions. Providers and recipients must agree to comply with the requirements for service provision.

2103.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the plan of care as necessary to avoid institutionalization.

1. Counseling Services
2. Habilitation
    - Community Day Habilitation
        - Day Habilitation
        - Prevocational Services
        - Educational Services
        - Supported Employment Services
    - Habilitative Residential Supports
        - Family Support Arrangement
        - Supported Living Services/Arrangement

2103.2B PROVIDER RESPONSIBILITY

1. All Providers:

    a. Must obtain and maintain a Waiver for Person's with Mental Retardation or Related Conditions provider type (38).
    b. May not bill for services provided by a recipient's spouse, a minor child's parent, a legal guardian, or a legally responsible adult.
    c. May only provide services that have been identified in the Individual Support Plan and that have a prior authorization.
    d. Must verify the Medicaid eligibility status of each Home and Community-based waiver recipient each month.
    e. Providers who supply services in their home will have safety inspections of their home. (Note: When the service is provided in the recipient's or family's home, no home inspection is required.

f. Providers who supply service to a recipient in the recipient's or family's home (FSA, SLA or respite services) shall have a criminal history clearance obtained from the Federal Bureau of Investigation through the submission of fingerprints to the FBI. (Note: When the service is provided by a family member, or a friend of the family, the recipient, family or guardian may waive these requirements if the Regional Center agrees per MHDS policy.)

1. The Medicaid Office will not enroll any person or entity convicted of a felony or misdemeanor under Federal or State Law for any offense which the State agency determines is inconsistent with the best interest of recipients. Such determinations are solely the responsibility of the Division.

2. The Medicaid Office may deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if:

a. the applicant or contractor has been convicted of:

1. Murder, voluntary manslaughter or mayhem;
2. Assault with intent to kill or to commit sexual assault or mayhem;
3. Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime.
4. Abuse or neglect of a child or contributory delinquency;
5. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS, within the past 7 years;
6. A violation of any provision of or NRS 200.700 through 200.760;
7. Criminal neglect of a patient as defined in NRS 200.495;
8. Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property, within the immediately preceding 7 years; or
9. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding 7 years;
10. Abuse, neglect, exploitation or isolation of older persons;
11. Kidnapping, false imprisonment or involuntary servitude;
12. Any offense involving assault or battery, domestic or otherwise;
13. Aiding, abetting or permitting the commission of any illegal act;

14. Conduct inimical to the public health, morals, welfare and safety of people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued.
15. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency, or
16. Any other offense determined by the Division to be inconsistent with the best interest of all recipients.

b. The applicant, or contractor, upon receiving information resulting from the FBI criminal background check, or from any other source, continues to employ a person who has been convicted of an offense as listed above.

3. If an employee, or independent contractor believes that the information provided as a result of the FBI criminal background check is incorrect, he or she may immediately inform the employing agency or the Division (respectively) in writing. An employing agency or the Division, that is so informed within 5 days, may give the employee, or independent contractor, a reasonable amount of time, but not more than 60 days, to provide corrected information before terminating the employment, or contract, of the person pursuant to this section

g. Must complete required training within six (6) months of beginning employment.
h. Each provider must accurately complete and sign the daily record for each recipient service. Periodically, Medicaid Staff may request this documentation to compare it to billings submitted. The records must be maintained by the provider for at least six (6) years after the date the claim is paid.
i. Each provider must cooperate with MHDS and/or State or Federal reviews or inspections.
j. Report any recipient incidents or problems to MHDS on a timely basis.

2. MHDS:

Maintains an Interlocal Contract with the Division of Health Care Financing and Policy to operate the Home and Community-based Waiver for Person's with Mental Retardation or Related Conditions.

3. All Service Providers other than MHDS:

Obtain and maintain a service provider contract with MHDS.

4. Agency Providers:

a. Agencies employing providers of service to the waiver program must arrange training in at least the following subjects:

1. Policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;
2. Procedures for billing and payment;
3. Record keeping and reporting;
4. Information about the specific needs and person centered goals of the recipients to be served;
5. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:
   a. understanding person centered goals;
   b. respecting consumer rights and needs;
   c. respect for age, cultural and ethnic differences;
   d. recognizing family relationships;
   e. confidentiality;
   f. respecting personal property; ethics in dealing with the recipient, family and other providers;
   g. handling conflict and complaints;
   h. and other topics as relevant.

6. Exemptions from Training

   a. The agency, may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

   b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

5. Individual Providers (Family Support Arrangement, Counseling)

a. The individual provider must understand the assigned tasks, the allotted time, record keeping responsibilities, and billing procedures for provided waiver service.
b. Individual providers must document the time spent and services provided to the recipient on a daily record. This record must be signed by the recipient and be available for the Medicaid or the service coordinator's review.

2103.2C Recipient Responsibilities

The recipient or the recipient's authorized representative will:

1. Notify the provider(s) and service coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and service coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and service coordinator of changes in medical status, service needs, address, and location, or of changes of status of legally responsible adult(s)/authorized representative.
4. Treat all staff and providers appropriately.
5. Sign the provider service logs/visit form(s) to verify services were provided.
6. Notify the provider when scheduled visits cannot be kept or services are no longer required.
7. Notify the provider of missed visits by provider staff.
8. Notify the provider of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
9. Furnish the provider with a copy of their Advance Directives.
10. Not request a provider to work more than the hours authorized in the service plan.
11. Not request a provider to provide service for a non-recipient, family, or household members.
12. Not request a provider to perform services not included in the Support Plan.
13. Contact the service coordinator to request a change of provider.
14. Sign all required forms.

2103.3 SERVICE COORDINATION (TARGETED CASE MANAGEMENT)

2103.3A COVERAGE AND LIMITATIONS

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the Waiver for Person's with Mental Retardation and Related Conditions and the service parameters referenced in MSM 2500 will therefore be included and delineated in this chapter as to how they are met for waiver recipients. Direct therapy service is not a covered service. Covered services are:

1. Assessment includes:
   a. Initial assessment and reassessment of the recipient's level of functioning to identify the full range of support needs every 12 months, or more often if needed.
   b. Evaluation and/or re-evaluation of level of care every 12 months or more often if needed.

2. Service Plan Development includes:

   Coordination and participation in the individual support team for development and/or review of the individual support plan every twelve months or more often if needed.

3. Referral/Linkage includes:
   a. Communication of the support plan to all affected providers, providing information about the recipient's medical history and level of functioning necessary to plan, deliver, and monitor supports.
   b. Coordination of multiple services and/or providers.
   c. Complete a prior authorization form and submit to Medicaid's Quality Improvement Organization (QIO-like vendor) for all waiver services.
   d. Identification of resources to meet applicant/recipient's unmet needs.
   e. Locating and assisting waiver applicants/recipients in gaining access to the needed services such as medical, social, educational, and other service, regardless of the funding source for the services to which access is gained.

4. Monitoring/Follow-up:
   a. Monitoring and documenting the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine the progress and compliance with the individual support plan. This monitoring of the quality of care will be completed through a monthly contact.
   b. Determining the cost effectiveness of each waiver service for each applicant/recipient.
   c. Preparing and reviewing necessary billing for Medicaid payments and authorizing payment for waiver services.
   d. Notifying all affected providers of changes in the recipient's medical status, support needs, address and location, or of change of the status of legally responsible adults or authorized representatives.
   e. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient.
   f. Notifying all affected providers of any recipient complaints regarding deliver of service or specific provider staff.
   g. Notifying all affected providers if a recipient requests a change n the provider staff or provider agency.

2103.3B PROVIDER RESPONSIBILITIES/QUALIFICATIONS

Case Management Services providers (Service Coordinators) must meet specific qualifications to assure adequate services are being provided. They must be Employees of the Division of Mental Health and Developmental Services (MHDS); meet one of the following criteria:

1. A psychiatrist licensed to practice medicine in Nevada and eligible for certification by the

American Board of Psychiatry and Neurology;
2. Psychologist licensed to practice in Nevada;
3. Licensed clinical social worker, psychiatric social worker, and associate in social work;
4. Registered nurse licensed in Nevada to practice professional nursing;
5. Mental retardation professional with at least a bachelor's degree in human sciences; or
6. A child development specialist and psychology, nursing or social work caseworker who work under the direct supervision of a person in classes a through e above.

2103.4 COUNSELING SERVICES

2103.4A COVERAGE AND LIMITATIONS

1. Counseling services provide assessment support and guidance in problem identification and resolution in areas of personal adaptation including interpersonal relationships, self-esteem, community participation, independence, families, friends and work. It may include skill development in social interaction, self-direction and problem solving. This service is provided based on the recipient's need to assure health, safety and welfare in the community.

2. If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive this waiver service.

2103.4B PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. All persons performing services to recipients from this category must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field. A closely allied field is rehabilitation counseling, alcohol and drug abuse counseling, or special education. A graduate level intern supervised by a licensed clinician or mental health counselor may provide these services. Professional experience in a setting serving persons with mental retardation is preferred.

2. Must have a Nevada license in Clinical Social Work, Marriage and Family Therapy or Clinical Psychology, or have a Masters in Counseling or closely allied field.

2103.4C RECIPIENT RESPONSIBILITIES

Refer to section 2103.1C

2103.5 COMMUNITY DAY HABILITATION

2103.5A COVERAGE AND LIMITATIONS

This service includes:

1. Day Habilitation

   a. Day habilitation provides assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. These services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's support plan.

   b. Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the support plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

   c. Transportation will be provided between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

2. Prevocational Services

   a. The prevocational services provided under this waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each individual receiving prevocational services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

   b. These services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. These services provide training for work skills such as self-direction, attendance, task completion, problem solving and safety and mobility training.

   c. When compensated, individuals are paid at less than 50 percent of the minimum wage.

   d. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span, social skills and motor skills. All prevocational services will be reflected in the individual's support plan as directed to habilitative, rather than explicit employment objectives.

   e. Transportation will be provided between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component

part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

3. Supported Employment Services

a. Supported employment services, which consist of paid employment for persons who, because of their disabilities, need intensive ongoing support to perform in a work setting in order to obtain and maintain their integrated employment. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to develop, and maintain paid work by individuals receiving waiver services, including supervision, training, job coaching and follow-along services. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment activities include:

1. Facility-based employment- Individuals are employed in a vocational location that provides a variety of work opportunities for the people served. Individuals receive wages commensurate with those paid non-disabled experienced worker in industry in the vicinity for essentially the same type, quality, and quantity of contract and piecework. The focus is on observation of work habits, attendance, interpersonal relations skills, communication skills, accuracy, productivity standards for quality and quantity, safety factors and physical tolerance. Activities included in this service are primarily directed at developing and enhancing job skills so people can obtain and maintain employment. Supports are reflected in the individual's support plan.

2. Enclaves - Individuals work as part of a group of people employed in integrated settings, with a variety of occupational opportunities, in which they may earn minimum or sub-minimum wage and supports are provided to the group by a provider supervisor. People are helped to maintain employment while also learning skills, which will allow them to be employed in jobs with less intensive supports. Enclaves are formed through agreements between providers and local businesses.

3. Supported competitive employment - People are employed in or are exploring integrated, competitive jobs. Supports include individualized training or job coaching, training of the employers to provide supports, and

long-term monitoring in order to maintain employment.

b. The supported employment services furnished under this waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving supported employment services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

c. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

d. Transportation will be provided between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

4. Educational Services

a. Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA.

b. Documentation will be maintained in the file of each individual receiving educational services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

5. If the recipient is in a Medicaid or Medicare funded hospice program, the recipient is not eligible to receive the community day habilitation waiver services.

2103.5B PROVIDER RESPONSIBILITIES

Community day habilitation services are provided by certified community training centers and/or other community providers who meet equivalent service standards and fulfill a demonstrated community need. To become a certified community-training center:

1. A private, non-profit organization must be approved as a Community Training Center (CTC) by the Nevada Mental Health and Developmental Services Commission, which is composed of mental health and developmental services professionals as well as representatives of the recipients of supports.
2. Annual certification is required for certified centers meeting requirements under NRS and NAC 435.

2103.6 HABILITATIVE RESIDENTIAL SUPPORTS

Habilitative residential supports services are designed to assist people in acquiring, retaining, and improving adaptive skills necessary to reside successfully in home and community-based settings.

2103.6A COVERAGE AND LIMITATIONS

The amount of supports are determined through the use of the MHDS approved assessment tool and other clinical assessment information related to risks to health and safety for the person and/or the community and the person's needs for medical and physical care. The type of supports are those identified in the person's Individual Support Plan (ISP) in coordination with the person-directed planning process. Assessment information is updated at least annually. These supports specifically exclude educational or autism specific services such as ABA, TEACCH, REC, PRT and other applied behavioral analysis type programs using discrete trail training.

These supports include either a Family Support Arrangement or a Supported Living Arrangement:

1. Family Support Arrangement (FSA)

   Family Support Arrangement (FSA) is residential support for individuals served and their families designed to maintain the person in the family home. Family Support Arrangements are provided for (1) minor children living with parents or other natural family member and (2) adults living with family members, relatives, spouse, or in-law.
   Family Support Arrangements for minor children living with parent(s) or other members of the child's natural family include supportive services designed to assist the family to keep the child at home and avoid institutional or out-of-home placement. Payment will not be made for services furnished to a minor by the child's parent or a legally responsible guardian. Family Support Arrangements are not a substitute for natural supports provided by family and others, but rather supplement those natural supports so the child is able to remain in their home. Services include:

   a Instruction provided to the child and/or family members, including instruction about supportive procedures and use of equipment specified in the support plan, behavior support procedures, and parenting skills. Instruction shall be provided as necessary to safely maintain the child at home;
   b. Supports to the child and/or family members designed to assist in the acquisition,

retention or improvement of the child's adaptive skills related to self-care, daily living, friendships, socialization, self-direction, communication, use of leisure time, recreation and community living;

c. Assistance related to positioning, transferring, completion of physical activities and activities of personal care.

d. Quality assurance will be completed with supervision and monitoring to assure the child's health and safety with activities of daily living;

e. Consultation and training provided by a behavior specialist or qualified clinician to family members, support persons, and/or the child for the purpose of enhancing quality of life, promoting success in family and community settings, and the development of appropriate supports. Consultation may include:
   1. Implementing functional assessment.
   2. Determining the goals of intervention.
   3. Designing support plans.
   4. Implementing the support plan and monitoring outcomes.

f. Respite services provided to individuals to meet planned or emergency needs of the care giving family members.

2. Family Support Arrangements for adults living with family, relative, spouse, or in-law includes supportive services designed to assist the person to be a contributing family member, support the family to keep their family member at home, and avoid institutional placement. Payment will not be made for services furnished to an individual by his/her legally responsible guardian, or to an individual by that person's spouse. Services include:

   a. Instruction provided to the person and/or family members, including instruction about supportive procedures and use of equipment specified in the support plan, behavior support procedures, and skills related to providing personal care. Instruction shall be provided as necessary to safely maintain the person in the family home;

   b. Supports to the person designed to assist in the acquisition, retention or improvement of adaptive skills related to self-care, daily living, relationships, socialization, self-direction, communication, use of leisure time, recreation, and community living;

   c. Assistance related to positioning, transferring, completion of prescribed physical activities and activities of personal care.

   d. Quality assurance will be completed with supervision and monitoring to assure the person's health and safety with activities of daily living;

   e. Consultation and training provided by a behavior specialist or qualified clinician to family members, support persons, and/or the person for the purpose of enhancing quality of life, promoting success in family and community settings, and the development of appropriate supports. Consultation may include:
      1. Implementing functional assessment.
      2. Determining the goals of intervention.

3. Designing support plans.
4. Implementing the support plan and monitoring outcomes.

f. Respite services provided to meet planned or emergency needs of the care giving family members.

All Family Support Arrangements will be included in a contract in accordance with the child or adult's Individual Support Plan and will be monitored and supervised by a service coordinator or someone who qualifies as an administrator/supervisor.

3. Supported Living Services/Arrangement

Supported Living Arrangements (SLA) provide residential support for people living in their own homes or host homes designed so that the person can live in the community and maximize his/her ability to participate fully as a member of the community. Supported living services can be provided for (1) minor children living in a licensed foster home or host home or receiving 24-hour supports from an authorized and approved provider agency, and (2) adults living either by themselves or sharing a home with other recipients or with others as specified below. SLA services are not provided to people residing with family members (see Family Support option above).

If an unrelated service provider lives in the home of the recipient, his/her living cost (rent and food) may be included as part of the cost of services.

SLA recipients receive services specified in their Individual Support Plan (ISP). These services may include:

a. Instruction provided to the person and/or people who provide direct support, including instruction about supportive procedures and use of equipment specified in the support plan, behavior supports procedures, and teaching procedures to maximize the person's skills and abilities, reduce dependency, and develop natural support systems. Instruction shall be provided as necessary to safely maintain the person in their home;
b. Instruction and support to the person for the acquisition and retention of adaptive skills, such as skills related to self-care, daily living, community living, mobility, safety, friendships, socialization, self-direction, communication, use of leisure time, recreation, budgeting and money management, health maintenance and self-medication;
c. Assistance related to positioning, transferring, completion of physical activities, and activities of personal care;
d. Quality assurance will be completed with supervision and monitoring to assure the person's health and safety at home and in the community with activities of daily and community living;
e. Consultation and training provided by a behavior specialist or qualified clinician to

family members, support persons, and/or the person for the purpose of enhancing quality of life, promoting success in family and community settings, and the development of appropriate supports. Consultation may include:

1. Determining the goals of intervention.
2. Implementing functional assessments.
3. Designing support plans.
4. Implementing the support plan and monitoring outcomes.

f. SLA recipients will have a Provider Program Coordinator. Provider Program Coordinators are employees of provider agencies and assure the provision of direct supports as identified in the person's Individual Support Plan. Provider Program Coordinators activities may include some of the following support services: schedule and attend ISP meetings, develop training programs, goals and service plans for people, obtain and coordinate community resources such as: Medicaid, SSI, SSDI, HUD, Food Stamps, etc. Assist the person with locating residences, problem solving and support with crisis management. Complete paperwork on behalf of the person, assist the person with budgeting, bill paying, and with scheduling appointments. Make home visits to observe the person's living environment, provide feedback and observe specialized services provided by the direct support staff to assure they have the necessary training to carry out the supports and services identified in the ISP. Provide information to the MHDS Regional Center to allow evaluation and assurance that support services provided are those defined in the ISP.

SLA services are provided under a contract with the provider that is developed and singed by service coordinator, the recipient and/or authorized representative and the provider. These services are billed to Medicaid as one service and exclude room and board costs. The SLA contract states the number of hours and types of service to be delivered.

4. If the recipient is in a Medicaid or Medicare funded hospice program, FSA and SLA service contracts will need to be reviewed to eliminate duplicative services. The recipient may be eligible to receive this waiver service.

2103.6B PROVIDER RESPONSIBILITIES/QUALIFICATIONS

Family Support Arrangement and Supported Living Arrangements are provided by individuals and agencies approved and registered by the Division of Mental Health and Developmental Services (MHDS) who act as providers of service. Providers must be approved by Medicaid as a Provider of service. Providers are responsible for providing required information to Medicaid to maintain approved provider status. Support providers must meet the following criteria:

Direct Support Personnel for FSA and SLA Services:

1. Age and educational requirements must be met according to MHDS policy.
2. All people who provide FSA or SLA services must have at least three reference checks prior to approval for providing services. Only one reference may be based on a personal relationship.
3. All people who provide FSA or SLA services must have a criminal Nevada State and FBI background check.
4. If the child or adult receiving support services has a chronic medical condition that puts the person at risk for medical intervention (e.g., seizure disorder, diabetes, respiratory condition, cardiovascular condition, difficulties with mobility, need for personal care to complete activities of daily living), the people who provide supports must have CPR and First Aid certification prior to working with the person. All other support personnel will have CPR/First Aid certification within 90 days of hire.
5. All residential support personnel will complete orientation and on-the-job training as specified in MHDS policy.

2103.7 PROVIDER ENROLLMENT TERMINATION PROCESS

Providers must comply with all DHCFP provider enrollment requirements, provider responsibilities/qualifications, and DHCFP provider agreement limitations. Provider non-compliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract.

2103.7A COVERAGE AND LIMITATIONS

All providers should refer to the Medicaid Services Manual Chapter 100 for enrollment procedures.

2103.8 INTAKE PROCEDURES:

Nevada Medicaid has developed policies and procedures to ensure fair and adequate access to the Home and Community-based Waiver for People with Mental Retardation and Relation Conditions.

2103.8A COVERAGE AND LIMITATIONS

1. SLOT PROVISION

a. The allocation of waiver slots is maintained at the Mental Health and Developmental Services regional offices. As waiver slots become available, MHDS determines how many slots may be allocated.

b. If a Home and Community-based Waiver for People with Mental Retardation or Related Conditions recipient voluntarily terminates from the waiver (e.g., moves out of state, fails to cooperate or requests that his or her waiver services be

terminated, etc.) then at a later date, wants to be considered for the waiver, that person's name will be placed on the waiting list based on a new referral date.

c. If a Home and Community-based Waiver for People with Mental Retardation or Related Conditions recipient involuntarily terminates from the waiver, (e.g., has been placed in a nursing facility, an intermediate care facility for the mentally retarded, or hospital), and after discharge from the facility wants to be considered for the waiver, if the discharge occurred in the same waiver year, and if that person still meets the eligibility criteria, that recipient will be placed back on the Waiver for People With Mental Retardation or Related Conditions.

2. TELEPHONE REFERRAL

a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local MHDS regional center and speaking to an intake worker. The intake worker will discuss the waiver including eligibility requirements of the waiver with the referring party or the potential applicant.

b. If the potential applicant wants to apply for the waiver, the intake worker will inform the applicant of the necessity to submit a Medicaid application to the Nevada State Welfare Division (NSWD).

c. If the intake worker determines during the referral process that the potential applicant does not appear to meet the waiver criteria of financial eligibility, diagnosis of mental retardation or related condition, have a level of care, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.

d. Even if the applicant does not appear eligible for the Waiver for People with Mental Retardation or Related Conditions, he or she must be verbally informed of the right to continue the Medicaid application process through NSWD, as well as the waiver program application process through MHDS. If, the NSWD determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing.

3. WAITING LIST/NO WAIVER SLOT IS AVAILABLE

Once MHDS has identified that the applicant appears eligible or the applicant wishes to continue with the intake process, or a Medicaid application has been made through NSWD, and there are no waiver slots available:

a. The applicant will be placed on the waiver waiting list with the date of the referral to MHDS and the waiting list prioritization as the ranking date.

1. Once an applicant is placed on the waiting list through MHDS, MHDS will e-mail information regarding the applicants who have applied for Medicaid waiver at NSWD and are waiting final approval, to the DHCFP Waiver Unit on a weekly basis.

   If it has been determined that no slot is expected to be available within the 90 day determination period MHDS will notify DHCFP to deny the application due to no slot available. The applicant will remain on the waiting list.

   If an applicant has been pending for 30 days, a pending notice stating why a decision has not been made will be sent to the applicant by the DHCFP Waiver Unit. If an applicant has not been approved within 60 days, another pending notice will be sent to the applicant by the Waiver Unit. If the applicant has not been approved after 90 days, the application will be denied and the DHCFP Waiver Unit will send out a Notice of Decision stating the reason for the denial.

4. A WAIVER SLOT IS AVAILABLE

Once a slot for the waiver is available, the applicant, who has been assigned a waiver slot, will be processed for the waiver.

a. The procedure used for processing an applicant will be as follows:

   1. The MHDS service coordinator will make certain that the Medicaid waiver application, through NSWD, has been completed or updated and will assist in this process as needed.

   2. The MHDS service coordinator will gather the diagnositic data, complete the waiver assessment, and the level of care assessment.

   3. An Authorization for Release of Information form is needed for all waiver recipients and provides written consent for MHDS to release information about the recipient to others.

      The applicant and/or an authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

      The MHDS service coordinator will inform the applicant and/or an authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Human Resources may share confidential information without a signed Authorization for Release of Information.

4. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an intermediate care facility for the mentally retarded. If the applicant and/or legal representative prefers placement in an intermediate care facility for the mentally retarded, the service coordinator will assist the applicant in arranging for facility placement.

5. The applicant/recipient will be given the right to request a hearing if not given a choice between home and community based services and intermediate care facility for the mentally retarded placement.

6. When the applicant/recipient is approved by MHDS for the waiver:

   a. A written individual support plan is developed in conjunction with the recipient and the Individual Support Team by the MHDS service coordinator for each recipient under the waiver. The individual support plan is based on the assessment of the recipient's health and welfare needs.

   b. The recipient, the recipient's family, or the legal representative/authorized representative should participate in the development of the individual support plan.

   c. The individual support plan is subject to the approval of the Central Office Waiver Unit of Medicaid.

   d. Recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in his/her written individual support plan. Current individual support plan information as it relates to the services provided must be given to all service providers.

7. All forms must be complete with signature and dates where required.

8. MHDS will forward all completed waiver program information plus a 2734 form requesting approval to the Medicaid Central Office Waiver Unit.

   a. If the application is not approved by the Medicaid Central Office Waiver Unit, the following will occur:

      1. A NOD stating the reason(s) for the denial will be sent to the applicant by the Medicaid Central Office Waiver Unit via the Hearings and Policy Unit

      2. A 2734 form will be sent to MHDS and NSWD by the Medicaid Central Office Waiver Unit stating that the

application has been denied and the reason(s) for the denial.

b. If the Medicaid Central Office Waiver Unit approves the application, the following will occur:

1. A 2734 form will be sent by the Medicaid Central Office Waiver Unit to MHDS and NSWD stating the application has been approved.

2. Once the Medicaid Central Office waiver Unit has approved and NSWD has approved, waiver services can be initiated.

9. If the applicant/recipient is denied by MHDS waiver services, then:

a. the MHDS service coordinator will send written notice to the Medicaid Central Office Waiver Unit.

b. the Medicaid Central Office Waiver Unit will send a Notice of Decision (NOD) to the applicant via the Hearing and Policy Unit of Medicaid stating the reason(s) why the application was denied by MHDS.

c. The Medicaid Central Office Waiver Unit will also send a 2734 form to MHDS and NSWD stating that the application was denied and the reason(s) for the denial.

5. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, the Medicaid eligibility determination date through NSWD, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

6. WAIVER COST

Medicaid must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2103.9 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible and only when the service is included in the approved individual support plan.

All individual support services must be prior authorized. Payment will not be made to providers unless there is a prior authorization.

2103.9A COVERAGE AND LIMITATIONS

All Providers (type 38) must complete the CMS 1500 for payment of waiver services. Incomplete, or inaccurate claims will be returned to the provider by Medicaid's fiscal agent. If the wrong form is submitted it will also be returned to the provider by Medicaid's fiscal agent.

2103.9B PROVIDER RESPONSIBILITY

Refer to Section 2105.1 of this Medicaid Services Manual for detailed instructions for completing the CMS 1500 form and for a list of covered procedure codes.

2103.10 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies providing personal care aide services to give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to Medicaid Services Manual Chapter 100 for further information.

2103.11 PERMANENT CASE FILE

a. For each approved waiver recipient, the service coordinator must maintain a permanent case file that documents services provided under the Waiver for People with Mental Retardation and Related Conditions.
b. This record must be maintained for six years after waiver services are discontinued.

2103.12 SERVICE COORDINATOR RECIPIENT CONTACTS

a. Monthly Contact

1. The service coordinator must have monthly contact with each waiver recipient, or a recipient's authorized or legal representative, or the recipient's direct care service provider. This may be a phone contact. At a minimum, there must be a direct contact visit with each recipient every 3 months.

2. During the monthly contact, the service coordinator assesses the recipient's condition, the recipient's satisfaction with services, assesses for any changes in services or providers, and determines whether the services are promoting the goal(s) stated on the individual support plan.

b. Reassessment

1. Recipients must be reassessed at least annually. The first reassessment must be completed within 12 months of the waiver approval date. The reassessment should be conducted in the recipient's home or service provision site.

2. The recipient must be reassessed when there is a significant change in his/her condition.

a. Reassessment Procedures

During the reassessment process, the service coordinator should:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1A6 of the Medicaid Services Manual Chapter 2100.

2. Re-assess the recipient's ability to perform activities of daily living, his/her medical and mental status and support systems.

3. Re-evaluate the services being provided and progress made toward the goal(s) stated on the individual support plan.

4. Develop a new individual support plan and review the waiver costs.

5. Re-assess the recipient's level of care.

2103.13 MEDICAID'S ANNUAL REVIEW

The State will have in place a formal system by which it assures the health and welfare of the recipients served on the waiver, the recipient's satisfaction with the services and the cost effectiveness of these services.

2103.13A COVERAGE AND LIMITATIONS

Medicaid (lead agency) and MHDS will collaboratively conduct an annual review of the waiver program.

1. Provide CMS with information on the impact of the waiver. This includes the type, amount, and cost of services provided under the waiver and provided under the state plan, and the health and welfare of the recipients served on the waiver.

2. Assure financial accountability for funds expended for Home and Community Based services.

3. Evaluate that all provider standards are continuously met, and that individual support plans are periodically reviewed to assure that services furnished are consistent with the identified needs of the recipients.

4. Evaluate the recipient's satisfaction with the waiver program.

5. Further assure all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2103.13B PROVIDER RESPONSIBILITIES

Providers must cooperate with Medicaid's annual review process.

2104 HEARINGS

2104.1 SUSPENDED WAIVER SERVICES

a. A recipient's case may be suspended, instead of closed, if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example: if a recipient is admitted to a hospital , nursing facility, or intermediate care facility for the mentally retarded). After receiving written documentation from the service coordinator of the suspension of waiver services, a NOD (Notice of Decision) identifying the effective date and the reason for suspension will be sent to the recipient by the Medicaid Central Office Waiver Unit.

b. If at the end of 45 days the recipient has not been removed from suspended status, the case must be closed. A Notice of Decision (NOD) identifying the 60th day of suspension as the effective date of closure and the reason for termination will be sent to the recipient by the Medicaid Central Office Waiver Unit on of before the 45th day of suspension.

c. Waiver services will not be paid for the days that a recipient's case is in suspension.

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital, nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR) before 60 days the service coordinator, within 5 working days of release must:

a. Complete a revised waiver assessment, if there has been a significant change in the recipient's condition or needs.

b. Complete a new individual support plan if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days a new individual support plan is not necessary. Documentation of the temporary change must be made in the service coordinator's notes. The date of the resolution must also be documented in the service coordinator's notes.

c. Complete a new service authorization if necessary.

d. Contact the service provider(s) to reestablish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

a. The applicant does not meet the criteria for being diagnosed with mental retardation or

having a condition related to mental retardation.

b. The applicant does not meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
c. The applicant has withdrawn their request for waiver services.
d. The applicant fails to cooperate with the service coordinator or the home and community based services providers in establishing and/or implementing the individual support plan, implementing waiver services, or verifying eligibility for waiver services.
e. The applicant's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
f. The agency has lost contact with the applicant.
g. The applicant fails to show a need for home and community based waiver services.
h. The applicant would not require imminent placement in an ICF/MR if home and community based services were not available.
i. The applicant has moved out of state.
j. Another agency or program will provide the services.
k. MHDS has filled the number of slots allocated to the Home and Community Based Waiver for Persons with Mental Retardation and Related Conditions. The applicant has been approved for the waiver waiting list and will be contacted when a slot is available.

When the application for waiver services is denied the service coordinator will send a notification (form 2734) to the Medicaid waiver unit identifying the reason for denial. The waiver unit will send a Notice of Decision (NOD) for Payment Authorization Request (Form 3582) to the applicant or the applicant's legal representative. The service coordinator will submit the form within 5 days of the date of denial of waiver services.

2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

a. The recipient no longer meets the criteria for being mentally retarded or having a condition related to mental retardation.
b. The recipient no longer meets the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
c. The recipient has requested termination of waiver services.
d. The recipient has failed to cooperate with the service coordinator or home and community based services providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
e. The recipient's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
f. The recipient fails to show a continued need for home and community based waiver services.
g. The recipient no longer requires imminent ICF/MR placement if home and community based services were not available. (Imminent placement means within 30 to 60 days.)

h. The recipient has moved out of state.
i. Another agency or program will provide the services.
j. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, intermediate facility for persons with mental retardation, or incarcerated).
k. Medicaid has lost contact with the recipient.
l. The recipient fails to pay patient liability.
m. The recipient has not utilized any waiver services over a 12 month period.

When a recipient is scheduled to be terminated from the waiver program, the service coordinator will send a notification (form 2734) to the Medicaid waiver unit identifying the reason for termination. The waiver unit will send a Notice of Decision (NOD) for Payment to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the NOD. Refer to Medicaid Services Manual Chapter 3100 for exceptions to the advance notice.

2104.5 REDUCTION OF WAIVER SERVICES

Reasons to reduce of waiver services:

a. The recipient no longer needs the number of service/support hours/days which were previously provided.
b. The recipient no longer needs the service/supports previously provided.
c. The recipient's support system is providing the service.
d. The recipient has failed to cooperate with the service coordinator or home and community based services providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
e. The recipient has requested the reduction of supports/services.
f. The recipient's ability to perform tasks has improved.
g. Another agency or program will provide the service.
h. Another service will be substituted for the existing service.

When there is a reduction of waiver services the service coordinator will send a notification (form 2734) to the Medicaid waiver unit identifying what the reduction is and the reason for the reduction. The waiver unit will send a NOD Form 3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the NOD.

2104.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

2104.6A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated and the recipient/applicant is eligible for readmission to the waiver as defined in Section 2103.1A.6 and 2103.6A1 "b" and "c" and

is requesting reapproval within 90 days of closure the service coordinator must complete the following:

a. A new waiver assessment;
b. A new Statement of Choice;
c. A new Individual Support Plan;
d. A new Level of Care Determination.

All forms must be complete with signatures and dates. All forms will be submitted to the Medicaid Central Office Waiver Unit for approval.

2. If a recipient is terminated from the waiver for more than 90 days, and slots are available, and the recipient/applicant is eligible for readmission to the waiver as defined in Section 2103.1A.6., a new complete waiver packet for a new authorization must be forwarded to the Medicaid Central Office Waiver Unit.

2104.6B PROVIDER RESPONSIBILITIES

MHDS will forward all necessary forms to the Medicaid Central Office Waiver Unit for approval.

There are no responsibilities for service providers.

2104.6C RECIPIENT RESPONSIBILITIES

Recipients must cooperate fully with the reauthorization process to assure approval of his/her request for readmission to the waiver.

2104.7 HEARINGS PROCEDURES

Please reference Medicaid Services Manual, Chapter 3100, Hearings, for hearings procedure.

2105 REFERENCES AND CROSS-REFERENCES

Chapter 100	Eligibility Coverage and Limitations
Chapter 1400	Home Health Agencies
Chapter 3100	Medicaid Hearings
Chapter 3200	Hospice Services
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3600	Managed Care Organization
Chapter 3700	Nevada Check Up

NSWD's Medicaid Eligibility MAABD Manual Section 360

2105.1 CONTACTS

a. Medicaid District Offices

1. Las Vegas (Covers Pahrump and Henderson.)
700 Belrose Street
Las Vegas, NV 89107
(702) 486-1550

2. Reno
1030 Bible Way
Reno, NV 89502
(775) 688-2811

3. Carson City
1100 E. William Street Ste 102
Carson City, NV 89701
(775) 684-0826

4. Elko (Covers Ely and Winnemucca.)
850 Elm Street
Elko, NV 89801
(775) 753-1191

5. Fallon (Covers Tonopah, Yerington and Hawthorne.)
111 Industrial Way
Fallon, NV 89406
(775) 423-3161

b. Mental Health and Development Services Offices

1. Desert Regional Center
1391 South Jones Blvd.
Las Vegas, NV 89102
(702) 486-8038

2. Sierra Regional Center
605 South 21st Street
Sparks, NV 89431
(775) 688-1930

3. Rural Regional Center
625 Fairview, Suite 120
Carson City, NV
(775) 687- 5162

c. PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

d. PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

e. PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238